

Correct address is:

Attn:	P.O. Box or Street Address	
City	State	Zip + 4 (Required)

(Section 1)**Injured Patients and Families Compensation Fund Exemption**

License # or Federal Employer # (FEIN)	NAME (Please Print)
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Instructions: If you are eligible and elect to exempt yourself, check **ONLY ONE** box below that best indicates your basis for your claimed exemption from mandatory provisions, benefits, and limitations in ch. 655, Wis. Stat. Provide effective date and sign form and return in enclosed envelope. You must complete all sections of the form for it to be valid. Personally identifiable information provided on this form will be used to update the Injured Patients and Families Compensation Fund data base, which is generally available to the public.

If you file an exemption for a period of time that you have previously been a Fund participant, i.e., had primary insurance coverage on file with the Fund and paid Fund assessments for same period, you MUST submit a written explanation.

(Section 2)

- ☐ 1. Effective _____ (M/D/YR), I will not practice in Wisconsin for more than 240 hours during a fiscal year. (July 1-June 30))
- ☐ 2. I am employed by the state, a county, or municipality. I will not practice outside that employment for more than 240 hours during a fiscal year (July 1-June 30). I claim this status effective _____ (M/D/YR).
- ☐ 3. I am a federal employee and covered under the Federal Tort Claims Act. I will not practice outside that employment for more than 240 hours during a fiscal year (July 1-June 30). I claim this status effective _____ (M/D/YR).
- ☐ 5. My principal place of practice is not Wisconsin. Effective _____ (M/D/YR), more than 50% of the income from my practice will be derived from outside Wisconsin or I will render services to more than 50% of my patients outside Wisconsin during a fiscal year (July 1-June 30).
- ☐ 6. Retired from or discontinued all medical practice in Wisconsin that requires a medical license as of _____ (M/D/YR).
- ☐ 7. I am licensed in Wisconsin but have not practiced in the state to date, or did not practice in the state from _____ (M/D/YR) to _____ (M/D/YR). The grant date of my Wisconsin license is _____ (M/D/YR).
- ☐ 8. This corporation/partnership/facility organized and operated in Wisconsin is no longer providing medical services in Wisconsin as of _____ (M/D/YR).
- ☐ 9. Effective _____ (M/D/YR) through _____ (M/D/YR) I will be temporarily ceasing practice for more than 90 consecutive days. If I do not know the effective date of my restarting practice, I must notify the Fund in writing of my return date.

I understand that if I claim an exemption, I will not have the protection of the Injured Patients and Families Compensation Fund. My status with the Fund will remain as reported above unless or until I, or an insurance carrier on my behalf, notify the Fund in writing, or through electronic filing, of a change in my status.

Signature	Telephone Number	Date Signed
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